FluWatch

Public Health Agency of Canada | Agence de la santé publique du Canada

April 19 to April 25, 2015 (week 16)

Overall Summary

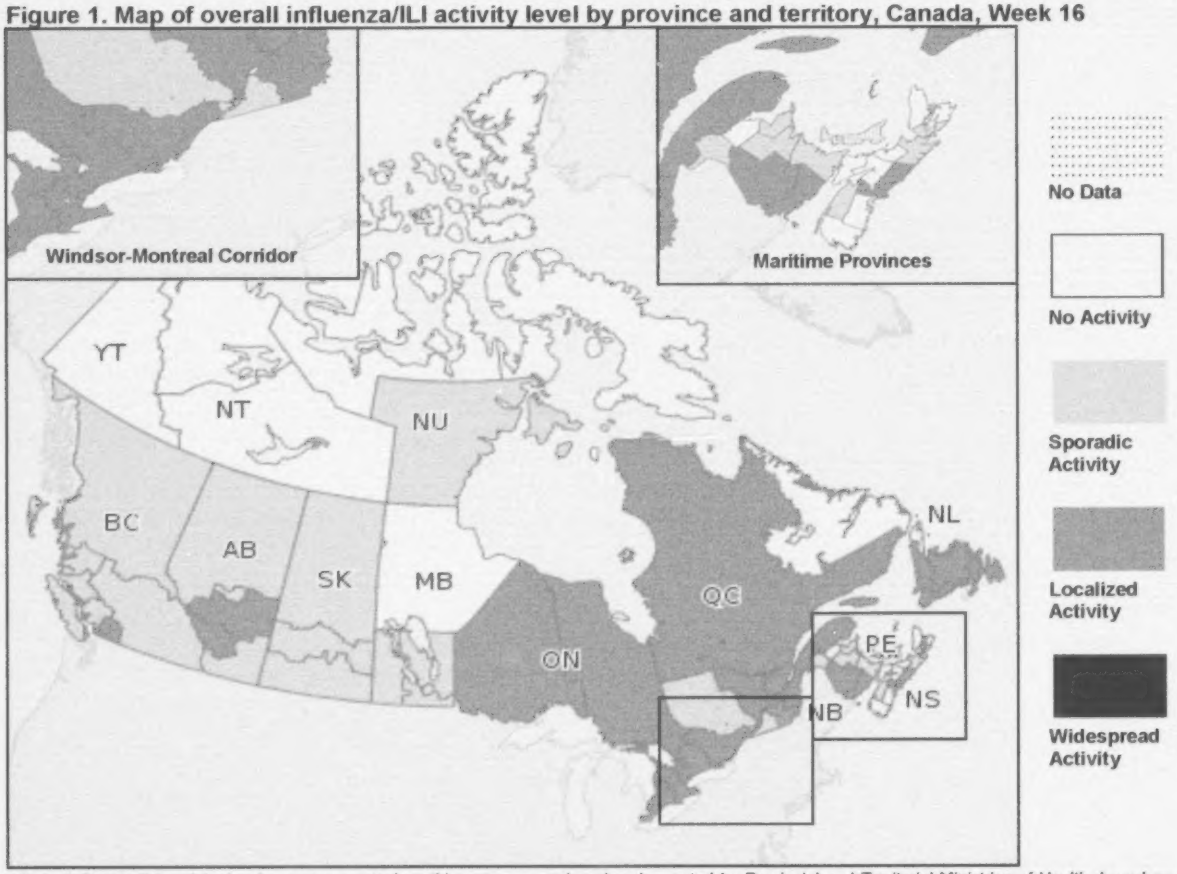
- Influenza B continued to be the most common influenza virus circulating in Canada. Detections of influenza B appeared to have peaked in week 12.
- Influenza B is having a greater impact on adults less than 65 years of age, compared to influenza A(H3N2), which predominated earlier in the season.
- Although overall influenza activity in Canada continued to decline, elevated activity was still reported in week 16 (mostly in the Central and Atlantic provinces).
- Fewer influenza hospitalizations were reported this week compared to the previous week. The majority of hospitalizations were due to influenza A and in adults ≥65 years of age.

Are you a primary health care practitioner (General Practitioner, Nurse Practitioner or Registered Nurse) interested in becoming a FluWatch sentinel for the 2014-15 influenza season? Contact us at FluWatch@phac-aspc.gc.ca

Influenza/ILI Activity (geographic spread)

In week 16, no regions reported widespread activity. Twenty regions reported localized activity: BC, AB(2), ON(7), QC(4), NB(2), NS and NL(3). Twenty-three regions reported sporadic activity: in NU, BC(4), AB(3), SK(3), MB(4), QC(2), NB(4), NS(2). Fourteen regions reported no activity activity: in YK, NT(2), NU(2), MB, NB, NS(6), and NL.

Figure 1. Map of overall influenza/ILI activity level by province and territory, Canada, Week 16

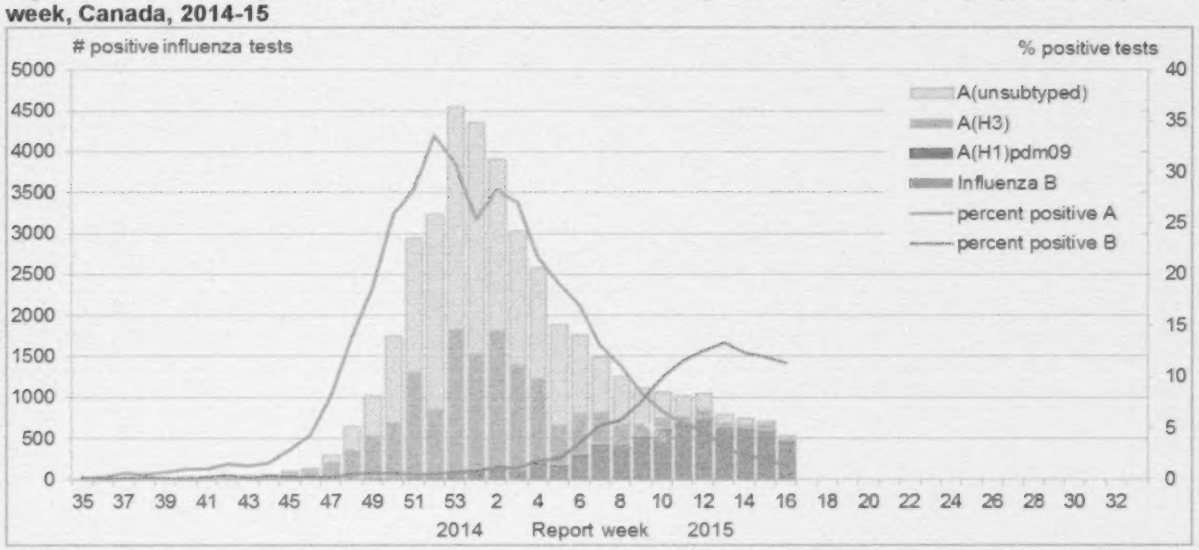


Note: Influenza/ILI activity levels, as represented on this map, are assigned and reported by Provincial and Territorial Ministries of Health, based on laboratory confirmations, sentinel ILI rates and reported outbreaks. Please refer to detailed definitions at the end of the report. Maps from previous weeks, including any retrospective updates, are available on the FluWatch website.

Influenza and Other Respiratory Virus Detections

In week 16, the percentage positive for influenza A (1.2%) and B (11.4%) declined from the previous week (Figure 2). Influenza B remained the predominant virus in week 16, representing 90% of influenza detections. Influenza B detections appeared to have peaked in week 12 (761 detections). In the 2013-14 season, influenza B peaked in week 15 (646 detections). More influenza B has been observed to date this season (7,306) compared to the same time during the 2013-14 season (6,104). To date, 83% of influenza detections have been influenza A, and 99% of those subtyped have been A(H3N2) (Table 1). To date this season, detailed information on age and type/subtype has been received for 36,155 cases (Table 2). Adults ≥65 years of age have predominantly been affected by influenza A, accounting for 62% of influenza A detections. Influenza B, while much smaller in numbers, is mainly affecting individuals less than 65 years of age, they account for 59% of influenza B detections.

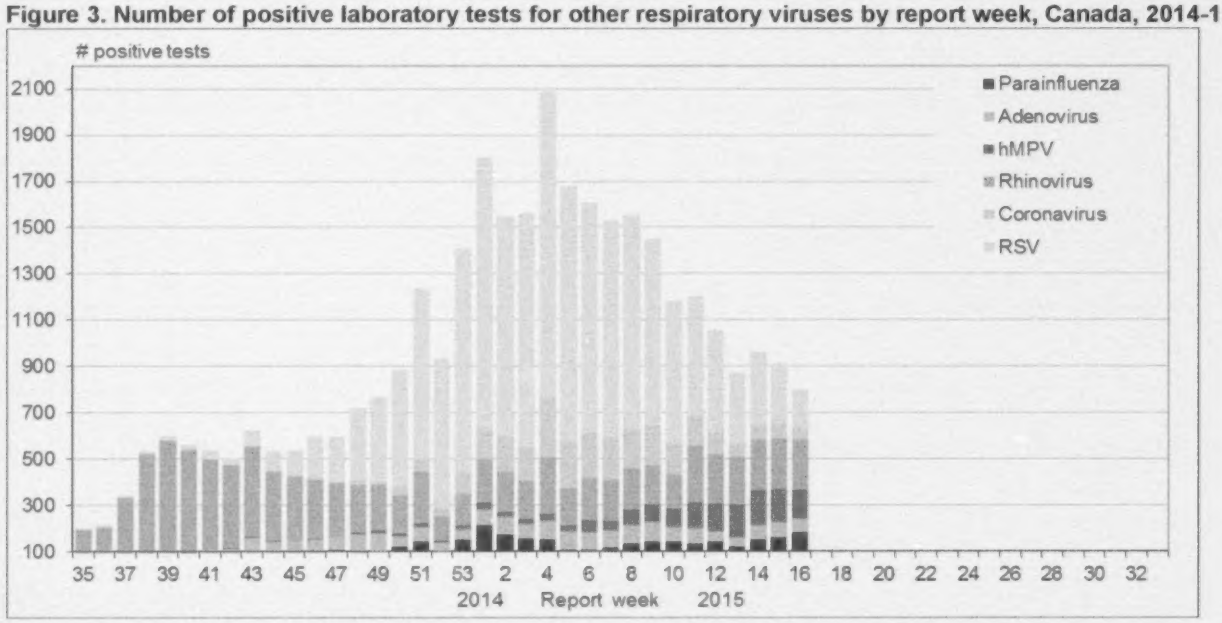
Figure 2. Number of positive influenza tests and percentage of tests positive, by type, subtype and report week, Canada, 2014-15



In week 16, detections for all other respiratory viruses remained similar to, or decreased from, the previous week (Figure 3). Overall, the detections of other respiratory viruses have been declining since peaking in week 5.

For more details, see the weekly Respiratory Virus Detections in Canada Report.

Figure 3. Number of positive laboratory tests for other respiratory viruses by report week, Canada, 2014-15



RSV: Respiratory syncytial virus; hMPV: Human metapneumovirus

Table 1. Weekly and cumulative numbers of positive influenza specimens by type, subtype and province, Canada, 2014-15

Reporting provinces[1]	Weekly (April 19 to April 25, 2015)					Cumulative (August 24, 2014 to April 25, 2015)				
	Influenza A				B	Influenza A				B
	A Total	A(H1)pdm09	A(H3)	A(UnS)	B Total	A Total	A(H1)pdm09	A(H3)	A(UnS)	B Total
BC	5	0	3	2	21	3517	28	2626	863	385
AB	9	1	6	2	39	3699	14	3529	156	844
SK	1	0	0	1	19	1313	0	839	474	238
MB	0	0	0	0	21	1122	0	390	732	165
ON	17	2	10	5	132	11131	48	4698	6385	1179
QC	11	0	0	11	175	11408	4	422	10982	3608
NB	5	0	3	2	49	1193	0	192	1001	484
NS	0	0	0	0	9	511	0	123	387	254
PE	1	0	1	0	1	131	1	128	2	108
NL	4	0	0	4	6	620	0	123	497	41
Canada	**53**	**3**	**23**	**27**	**472**	**34645**	**95**	**13070**	**21479**	**7306**
Percentage[2]	10.1%	5.7%	43.4%	50.9%	89.9%	82.6%	0.3%	37.7%	62.0%	17.4%

Table 2. Weekly and cumulative numbers of positive influenza specimens by type, subtype and age-group reported through case-based laboratory reporting[3], Canada, 2014-15

Age groups (years)	Weekly (April 19 to April 25, 2015)					Cumulative (August 24, 2014 to April 25, 2015)						
	Influenza A				B	Influenza A				B	Influenza A and B	
	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	#	%
<5	2	1	0	1	26	2087	22	808	1257	469	2556	7.1%
5-19	3	0	1	2	23	1782	6	956	820	683	2465	6.8%
20-44	4	0	3	1	33	3433	16	1668	1749	922	4355	12.0%
45-64	4	1	1	2	60	3859	21	1656	2182	1565	5424	15.0%
65+	15	0	4	11	132	18697	15	7272	11410	2531	21228	58.7%
Unknown	0	0	0	0	0	120	0	101	19	7	127	0.4%
Total	28	2	9	17	274	29978	80	12461	17437	6177	36155	100.0%
Percentage[2]	9.3%	7.1%	32.1%	60.7%	90.7%	82.9%	0.3%	41.6%	58.2%	17.1%		

[1] Specimens from NT, YT, and NU are sent to reference laboratories in other provinces. Cumulative data includes updates to previous weeks.
[2] Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections.
[3] Table 2 includes specimens for which demographic information was reported. These represent a subset of all positive influenza cases reported.
UnS: unsubtyped: The specimen was typed as influenza A, but no result for subtyping was available.

Antiviral Resistance

During the 2014-2015 influenza season, the NML has tested 1,317 influenza viruses for resistance to oseltamivir and 1,313 influenza viruses for resistance to zanamivir. All viruses were sensitive to zanamivir and one influenza A(H3N2) virus was resistant to oseltamivir. A total of 1,324 influenza A viruses (99.9%) were resistant to amantadine (Table 3).

Table 3. Antiviral resistance by influenza virus type and subtype, Canada, 2014-15

Virus type and subtype	Oseltamivir		Zanamivir		Amantadine	
	# tested	# resistant (%)	# tested	# resistant (%)	# tested	# resistant (%)
A (H3N2)	867	1	864	0	1313	1312 (99.9%)
A (H1N1)	10	0	10	0	12	12 (100%)
B	440	0	439	0	NA[1]	NA[1]
TOTAL	1317	1	1313	0	1325	1324

[1]NA: Not Applicable

Influenza Strain Characterizations

During the 2014-2015 influenza season, the National Microbiology Laboratory (NML) has characterized 716 influenza viruses [181 A(H3N2), 14 A(H1N1) and 521 influenza B].

Influenza A (H3N2): When tested by hemagglutination inhibition (HI) assay (n=181), one virus was antigenically similar to A/Texas/50/2012, five showed reduced titers to A/Texas/50/2012 and 175 were antigenically similar to A/Switzerland/9715293/2013, which is the influenza A(H3N2) component recommended for the 2015 Southern Hemisphere influenza vaccine. Additionally, 1,091 A(H3N2) viruses were unable to be tested by HI assay; however, sequence analysis showed that 1,089 belonged to a genetic group that typically shows reduced titers to A/Texas/50/2012. **Influenza A(H1N1):** Fourteen A(H1N1) viruses characterized were antigenically similar to A/California/7/2009. **Influenza B:** Of the 521 influenza B viruses characterized, 495 viruses were antigenically similar to B/Massachusetts/2/2012, three viruses showed reduced titers against B/Massachusetts/2/2012, and 23 were B/Brisbane/60/2008-like (Figure 4).

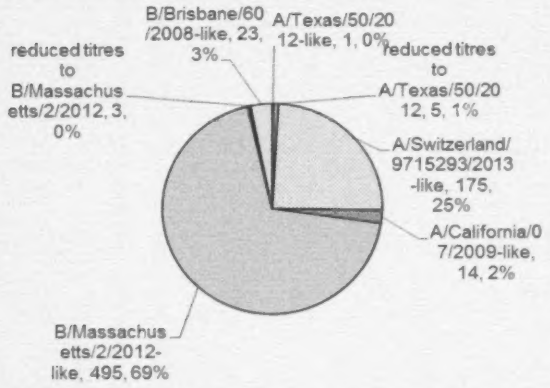


Figure 4. Influenza strain characterizations, Canada, 2014-15, N = 716

The NML receives a proportion of the number of influenza positive specimens from provincial laboratories for strain characterization and antiviral resistance testing. Characterization data reflect the results of haemagglutination inhibition (HAI) testing compared to the reference influenza strains recommended by WHO.

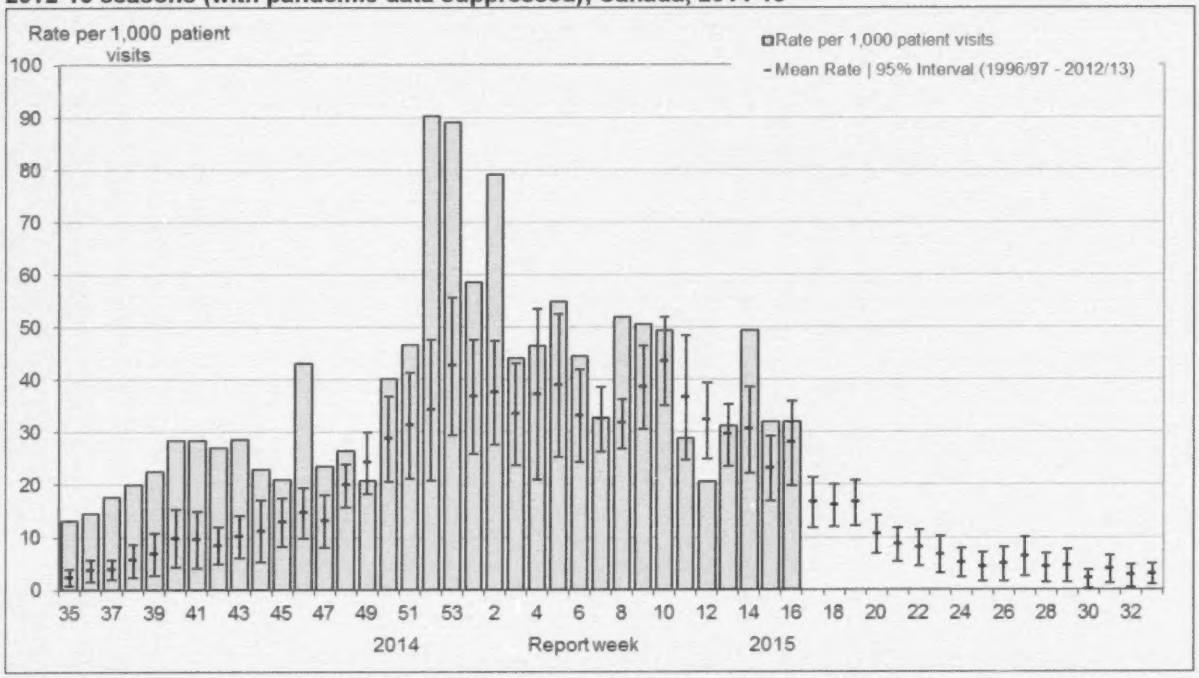
The recommended components for the 2014-2015 northern hemisphere trivalent influenza vaccine include: an A/California/7/2009(H1N1)pdm09-like virus, an A/Texas/50/2012 (H3N2)-like virus, and a B/Massachusetts/2/2012-like virus (Yamagata lineage). For quadrivalent vaccines, the addition of a B/Brisbane/60/2008-like virus is recommended.

The WHO has released the recommended composition of the influenza vaccine for the northern hemisphere for the 2015-2016 season. Trivalent vaccines are recommended to contain 1) an A/California/7/2009 (H1N1)pdm09-like virus 2) an A/Switzerland/9715293/2013 (H3N2)-like virus, and 3) an B/Phuket/3073/2013-like virus(Yamagata lineage). Quadrivalent vaccines are recommended to additionally contain a B/Brisbane/60/2008-like virus (Victoria lineage).

Influenza-like Illness Consultation Rate

In week 16, the national influenza-like-illness (ILI) consultation rate remained similar to the previous week at 31.9 consultations per 1,000 (Figure 5).

Figure 5. Influenza-like-illness (ILI) consultation rates by report week, compared to the 1996-97 through to 2012-13 seasons (with pandemic data suppressed), Canada, 2014-15

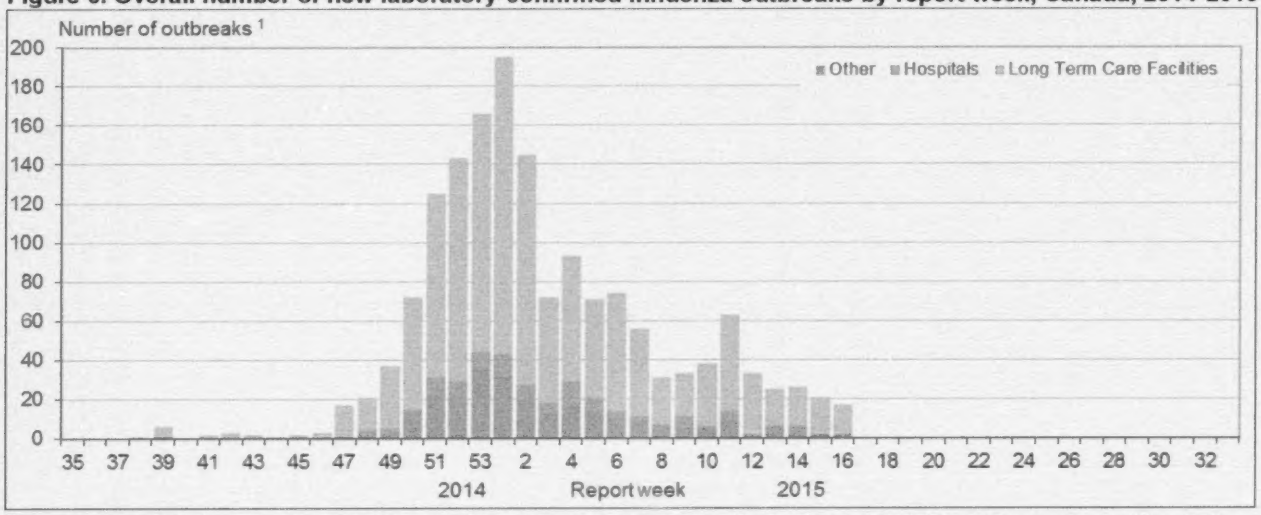


No data available for mean rate for weeks 19 to 39 for the 1996-1997 through 2002-2003 seasons. Delays in the reporting of data may cause data to change retrospectively. The calculation of the average ILI consultation rate over 17 seasons was aligned with influenza activity in each season. In BC, AB, and SK, data is compiled by a provincial sentinel surveillance program for reporting to FluWatch. Not all sentinel physicians report every week.

Influenza Outbreak Surveillance

In week 16, 17 new outbreaks of influenza were reported. Similar to previous weeks, the majority of the outbreaks occurred in the Central and Atlantic provinces. Fifteen outbreaks were reported in long-term care facilities (LTCF), and two in institutional or community settings (Figure 6). Among the outbreaks in which the influenza type was known (n=8), six outbreaks were associated with influenza B. To date this season, 1,246 outbreaks in LTCFs have been reported and the majority of those with known subtypes were attributable to A(H3N2). There have been a higher number of reported influenza outbreaks to date this season compared to the same period in previous seasons.

Figure 6. Overall number of new laboratory-confirmed influenza outbreaks by report week, Canada, 2014-2015

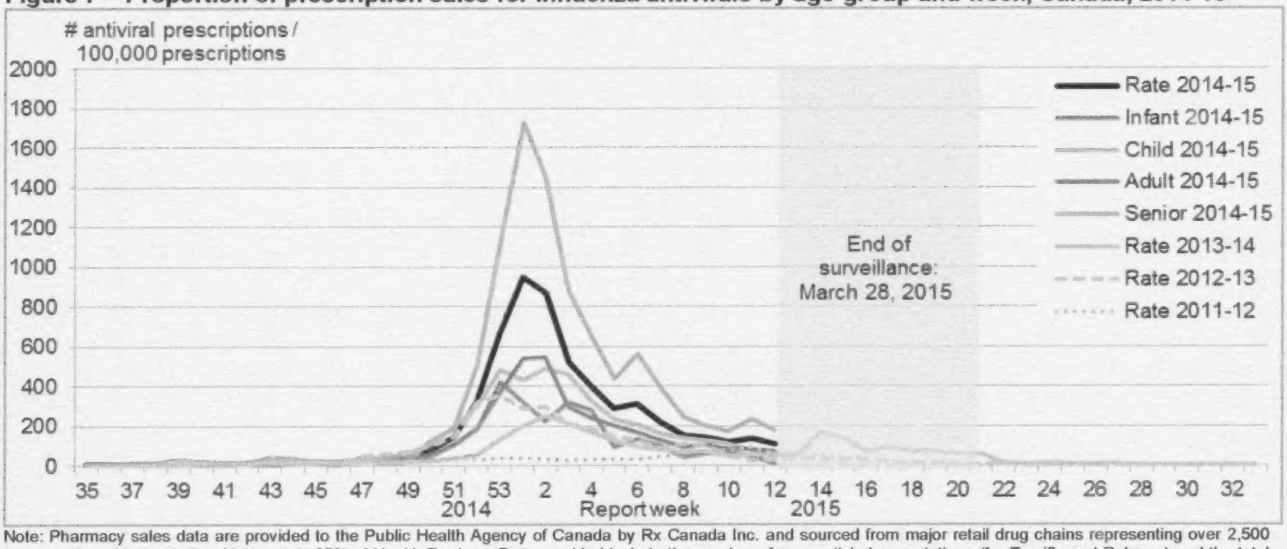


[1]All provinces and territories except NU report influenza outbreaks in long-term care facilities. All provinces and territories with the exception of NU and QC report outbreaks in hospitals. Outbreaks of influenza or influenza-like-illness in other facilities are reported to FluWatch but reporting varies between jurisdictions. Outbreak definitions are included at the end of the report.

Pharmacy Surveillance

Pharmacy surveillance for sales of influenza antivirals has ended for the 2014-2015 influenza season (Figure 7).

Figure 7 – Proportion of prescription sales for influenza antivirals by age-group and week, Canada, 2014-15



Note: Pharmacy sales data are provided to the Public Health Agency of Canada by Rx Canada Inc. and sourced from major retail drug chains representing over 2,500 stores nationwide (excluding Nunavut) in 85% of Health Regions. Data provided include the number of new antiviral prescriptions (for Tamiflu and Relenza) and the total number of new prescriptions dispensed by Province/Territory and age group. Age-groups: Infant: 0-2y, Child: 2-18y; Adult: 19-64y, Senior: ≥65y

Sentinel Hospital Influenza Surveillance

Paediatric Influenza Hospitalizations and Deaths (IMPACT)

In week 16, nine laboratory-confirmed influenza-associated paediatric (≤16 years of age) hospitalizations were reported by the Immunization Monitoring Program Active (IMPACT) network. Seven cases were influenza B (Figure 8a). A greater proportion of cases have been reported with influenza B in recent weeks, following the trend in laboratory detections. Among the reported cases, two (22%) were <2 years of age, six (67%) were 2 to 9 years of age and one (11%) was 10-16 years of age. No ICU cases were reported.

To date this season, 667 hospitalizations have been reported by the IMPACT network, 508 (76%) of which were cases of influenza A. Among cases for which the influenza A subtype was reported, 99% (162/164) were A(H3N2) (Table 4). To date, 82 cases were admitted to the ICU, of which 45 (55%) were 2 to 9 years of age (Figure 9a). A total of 54 ICU cases reported to have at least one underlying condition or comorbidity. Four deaths have been reported.

Note: The number of hospitalizations reported through IMPACT represents a subset of all influenza-associated paediatric hospitalizations in Canada. Delays in the reporting of data may cause data to change retrospectively.

Adult Influenza Hospitalizations and Deaths (CIRN)

In week 16, 11 laboratory-confirmed influenza-associated adult (≥16 years of age) hospitalizations were reported by the PHAC/CIHR Influenza Research Network (CIRN) Serious Outcomes Surveillance (SOS) network. Among the cases in week 16, 8 cases (73%) were in adults over the age of 65 (Figure 8b). One death was reported in week 16 in an adult over the age of 65 years.

To date this season, 2,204 cases have been reported; 1,910 (87%) with influenza A. The majority of cases (81%) were among adults ≥65 years of age (Table 5). One hundred and sixty nine ICU admissions have been reported and 127 cases were adults ≥65 years of age. Among the 169 ICU admissions, 24 were due to influenza B (10 in adults 45 to 64 years of age and 14 in adults over the age of 65). A total of 121 ICU cases (70%) reported to have at least one underlying condition or comorbidity. Of the 118 ICU cases with known immunization status, 39 (33%) reported not having been vaccinated this season. One hundred and thirty-three deaths have been reported, 123 (92%) of the deaths were adults >65 years of age (Figure 9B).

Note: The number of hospitalizations reported through PCIRN represents a subset of all influenza-associated adult hospitalizations in Canada. Delays in the reporting of data may cause data to change retrospectively.

Table 4 – Cumulative numbers of paediatric hospitalizations with influenza reported by the IMPACT network, Canada, 2014-15

Age groups	Cumulative (24 Aug. 2014 to 25 Apr. 2015)					
	Influenza A				B	Influenza A and B
	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	# (%)
0-5m	81	0	18	63	10	91 (13.6%)
6-23m	112	2	35	75	32	144 (21.6%)
2-4y	125	1	39	85	43	168 (25.2%)
5-9y	130	0	44	86	45	175 (26.2%)
10-16y	60	0	25	35	29	89 (13.3%)
Total	508	3	161	344	159	667
% [1]	76.2%	0.6%	31.7%	67.7%	23.8%	100.0%

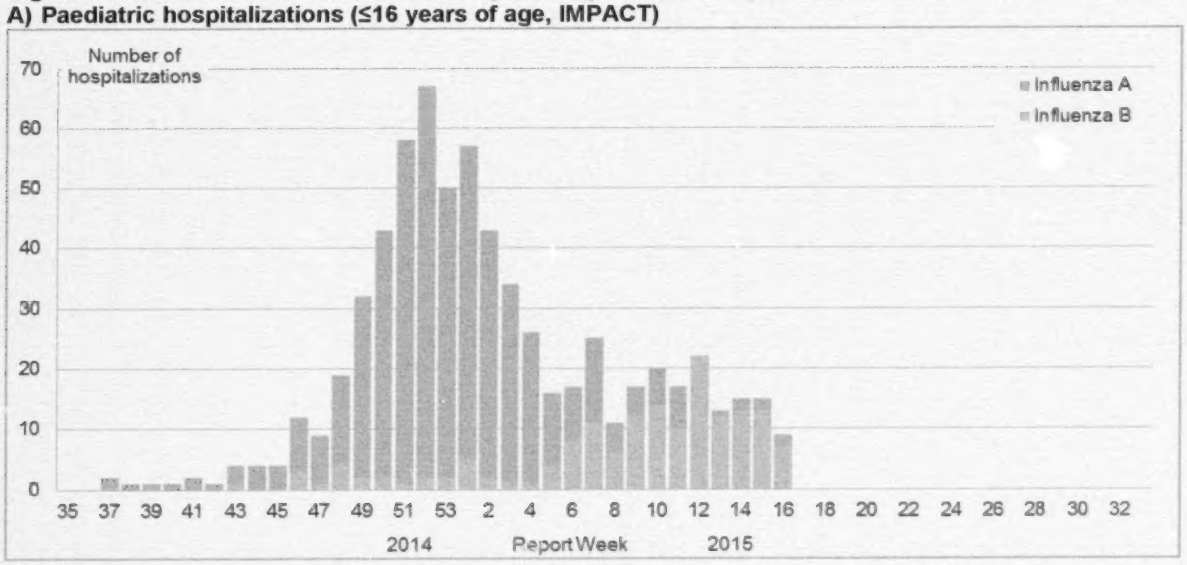
Table 5 – Cumulative numbers of adult hospitalizations with influenza reported by the PCIRN-SOS network, Canada, 2014-15

Age groups (years)	Cumulative (15 Nov. 2014 to 25 April 2015)					
	Influenza A				B	Influenza A and B
	A Total	A(H1) pdm09	A(H3)	A(UnS)	Total	# (%)
16-20	3	0	1	2	1	4 (0.2%)
20-44	105	1	55	49	15	120 (5%)
45-64	216	3	98	115	70	286 (13%)
65+	1586	4	760	822	208	1794 (81%)
Total	1910	8	914	988	294	2204
%	87%	0%	48%	52%	13%	100%

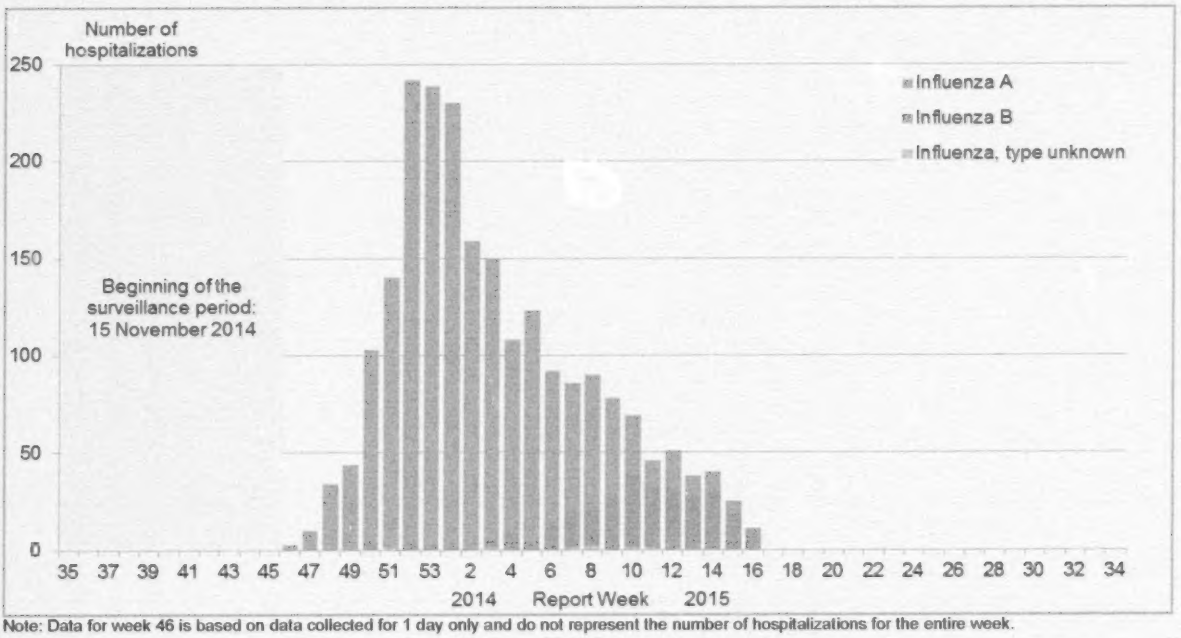
[1] Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections. UnS: unsubtyped: The specimen was typed as influenza A, but no result for subtyping was available.

Figure 8 – Number of cases of influenza reported by sentinel hospital networks, by week, Canada, 2014-15

A) Paediatric hospitalizations (≤16 years of age, IMPACT)



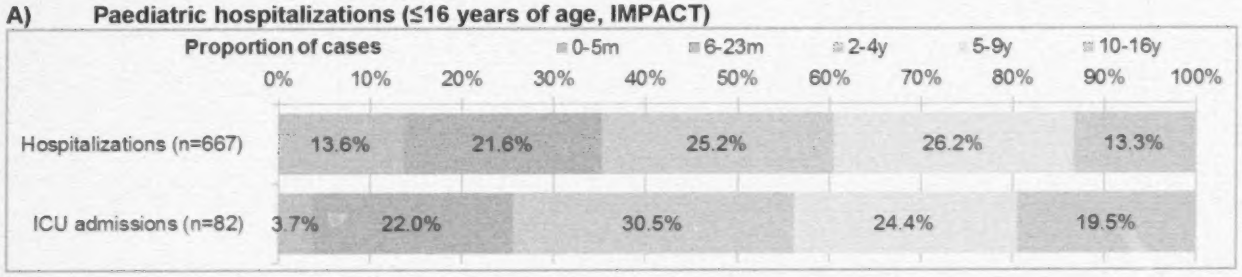
B) Adult hospitalizations (≥16 year of age, PCIRN-SOS)



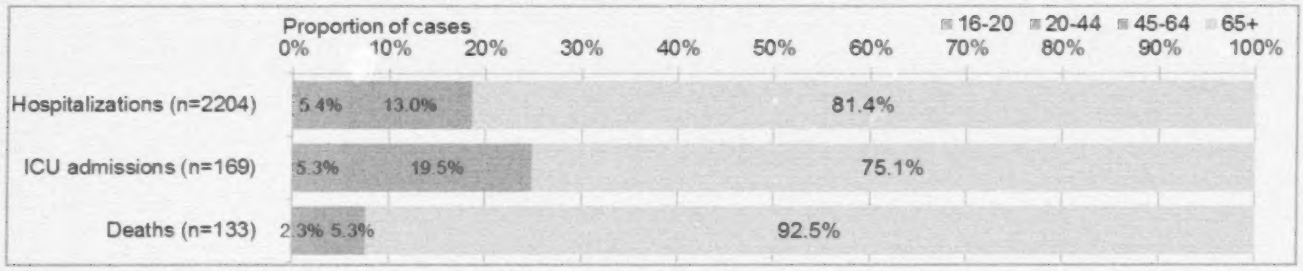
Note: Data for week 46 is based on data collected for 1 day only and do not represent the number of hospitalizations for the entire week.

Figure 9 – Percentage of hospitalizations, ICU admissions and deaths with influenza reported by age-group, Canada, 2014-15

A) Paediatric hospitalizations (≤16 years of age, IMPACT)



B) Adult hospitalizations (≥16 year of age, PCIRN-SOS)



Provincial/Territorial Influenza Hospitalizations and Deaths

In week 16, 99 laboratory-confirmed influenza-associated hospitalizations were reported from participating provinces and territories*, which is lower than the number reported the previous week. Of the 99 hospitalizations, 63 (64%) were due to influenza A and 63 (64%) were in patients ≥65 years of age.

Since the start of the 2014-15 season, 7,231 hospitalizations have been reported; 6,414 (89%) with influenza A. Among cases for which the subtype of influenza A was reported, 99.4% were A(H3N2). The majority of cases (71%) were ≥65 years of age (Table 6). A total of 375 ICU admissions have been reported to date: 53% (n=199) were in adults ≥65 years of age and 33% (n=123) were in adults 20-64 years. A total of 547 deaths have been reported since the start of the season: four children <5 years of age, four children 5-19 years, 33 adults 20-64 years, and 506 adults ≥65 years of age. Adults 65 years of age or older represent 93% of all deaths reported this season. Detailed clinical information (e.g. underlying medical conditions) is not known for these cases

* Note: Influenza-associated hospitalizations are not reported to PHAC by the following Provinces and Territory: BC, NU, and QC. Only hospitalizations that require intensive medical care are reported by Saskatchewan. ICU admissions are not distinguished among hospital admissions reported from Ontario. Data may also include cases reported by the IMPACT and PCIRN networks. The number of new influenza-associated hospitalizations and deaths reported for the current week may include cases from Ontario that occurred in previous weeks, as a result of retrospective updates to the cumulative total. It is important to note that the hospitalization or death does not have to be attributable to influenza, a positive laboratory test is sufficient for reporting.

Table 6 – Cumulative number of hospitalizations with influenza reported by the participating provinces and territories, Canada, 2014-15

Age groups (years)	Cumulative (24 Aug. 2014 to 25 Apr. 2015)					
	Influenza A				B	Influenza A and B
	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	# (%)
0-4	419	2	151	266	61	480 (7%)
5-19	277	2	136	139	87	364 (5%)
20-44	379	4	229	146	97	476 (7%)
45-64	608	7	256	345	112	720 (10%)
65+	4675	3	2217	2455	440	5115 (71%)
Unknown	56	1	52	3	20	76 (1%)
Total	6414	19	3041	3354	817	7231
Percentage[†]	88.7%	0.3%	47.4%	52.3%	11.3%	100.0%

[†] Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections.
UnS: unsubtyped: The specimen was typed as influenza A, but no result for subtyping was available.

See additional data on Reported Influenza Hospitalizations and Deaths in Canada: 2009-10 to 2014-15 on the Public Health Agency of Canada website.

Emerging Respiratory Pathogens

Human Avian Influenza

Influenza A(H7N9): Since the last FluWatch report, no new laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus were reported by the World Health Organization. Globally to April 30, 2015, the WHO reported a total of 651 laboratory-confirmed human cases with avian influenza A(H7N9) virus, including 225 deaths. Documents related to the public health risk of influenza A(H7N9), as well as guidance for health professionals and advice for the public is updated regularly on the following websites:

PHAC – Avian influenza A(H7N9)
WHO – Avian Influenza A(H7N9)

Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

Since the last FluWatch report, four new laboratory-confirmed cases of MERS-CoV have been reported by the World Health Organization. Globally, from September 2012 to April 30, 2015, the WHO has reported a total of 1,110 laboratory-confirmed cases of infection with MERS-CoV, including 422 deaths. All cases have either occurred in the Middle East or have had direct links to a primary case infected in the Middle East. The public health risk posed by MERS-CoV in Canada remains low (see the PHAC Assessment of Public Health Risk) and for the latest global risk assessment posted by the WHO on February 5, 2015: WHO MERS-CoV

Documents related to the public health risk of MERS-CoV, as well as guidance for health professionals and advice for the public is updated regularly on the following websites:

PHAC – Middle East respiratory syndrome coronavirus (MERS-CoV)
WHO – Coronavirus infections

Avian Influenza A(H5)

The Canadian Food Inspection Agency (CFIA) is continuing its investigation into the second outbreak of highly pathogenic avian influenza H5N2 virus in Oxford County, Ontario. To date, there has been three infected commercial premises. Individual quarantines and Avian Influenza Control Zones have been established. No human cases have been reported. Avian influenza viruses do not pose risks to food safety when poultry and poultry products are properly handled and cooked. Avian influenza rarely affects humans that do not have consistent contact with infected birds. Further information on the outbreak is provided on the following CFIA website:

CFIA - Notifiable Avian Influenza

International Influenza Reports

World Health Organization influenza update
World Health Organization FluNet
WHO Influenza at the human-animal interface
Centers for Disease Control and Prevention seasonal influenza report
European Centre for Disease Prevention and Control - epidemiological data
South Africa Influenza surveillance report
New Zealand Public Health Surveillance
Australia Influenza Report
Pan-American Health Organization Influenza Situation Report

FluWatch Definitions for the 2014-2015 Season

Abbreviations: Newfoundland/Labrador (NL), Prince Edward Island (PE), New Brunswick (NB), Nova Scotia (NS), Quebec (QC), Ontario (ON), Manitoba (MB), Saskatchewan (SK), Alberta (AB), British Columbia (BC), Yukon (YT), Northwest Territories (NT), Nunavut (NU).

Influenza-like-illness (ILI): Acute onset of respiratory illness with fever and cough and with one or more of the following - sore throat, arthralgia, myalgia, or prostration which is likely due to influenza. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.

ILI/Influenza outbreaks

Schools: Greater than 10% absenteeism (or absenteeism that is higher (e.g. >5-10%) than expected level as determined by school or public health authority) which is likely due to ILI. Note: it is recommended that ILI school outbreaks be laboratory confirmed at the beginning of influenza season as it may be the first indication of community transmission in an area.

Hospitals and residential institutions: two or more cases of ILI within a seven-day period, including at least one laboratory confirmed case. Institutional outbreaks should be reported within 24 hours of identification. Residential institutions include but not limited to long-term care facilities (LTCF) and prisons.

Workplace: Greater than 10% absenteeism on any day which is most likely due to ILI.

Other settings: two or more cases of ILI within a seven-day period, including at least one laboratory confirmed case; i.e. closed communities.

Note that reporting of outbreaks of influenza/ILI from different types of facilities differs between jurisdictions.

Influenza/ILI Activity Levels

1 = **No activity:** no laboratory-confirmed influenza detections in the reporting week, however, sporadically occurring ILI may be reported

2 = **Sporadic:** sporadically occurring ILI and lab confirmed influenza detection(s) with **no outbreaks** detected within the influenza surveillance region†

3 = **Localized:** (1) evidence of increased ILI* ;
(2) lab confirmed influenza detection(s);
(3) **outbreaks** in schools, hospitals, residential institutions and/or other types of facilities occurring in **less than 50% of the influenza surveillance region**†

4 = **Widespread:** (1) evidence of increased ILI*;
(2) lab confirmed influenza detection(s);
(3) **outbreaks** in schools, hospitals, residential institutions and/or other types of facilities occurring **in greater than or equal to 50% of the influenza surveillance region**†

Note: ILI data may be reported through sentinel physicians, emergency room visits or health line telephone calls.

** More than just sporadic as determined by the provincial/territorial epidemiologist.*

† Influenza surveillance regions within the province or territory as defined by the provincial/territorial epidemiologist.

We would like to thank all the Fluwatch surveillance partners who are participating in this year's influenza surveillance program.

This report is available on the Public Health Agency website at the following address: http://www.phac-aspc.gc.ca/fluwatch/index.html.

Ce rapport est disponible dans les deux langues officielles.